

FLU VACCINATION
65 Years & Older
CONSENT FORM

PARTICIPANT TO COMPLETE - PLEASE PRINT LEGIBLY

Print Name: _____ Sex: M F Phone: (_____) _____ - _____
Check One

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ Age: ____ E-mail Address: _____
MM DD YY (65 years & older)

PLEASE CHECK YES OR NO FOR EACH QUESTION

YES NO

1. Are you 64 years of age or younger? (Must be 65+ years of age...If yes, you can NOT receive this flu shot) YES NO
2. Are you allergic to eggs, egg proteins or any component of the vaccine? YES NO
3. Have you had a previous serious allergic reaction to the flu shot? YES NO
4. Do you have a current fever; or moderate or severe illness? YES NO
5. Do you have a history of Guillain-Barré Syndrome? YES NO



If you answered "yes" on questions 1-5 above you can NOT receive the 65+ flu vaccine at this time. Consult with your physician.
If you have any questions, please ask now before receiving the vaccine. If you experience any significant delayed reactions, SEE YOUR PHYSICIAN.

PRESENT YOUR INSURANCE CARD AT THE CLINIC - MUST BE PRIMARY PLEASE CHECK WITH YOUR INSURANCE TO VERIFY COVERAGE

- | | |
|--|--|
| <input type="checkbox"/> Aetna (No HCA) | <input type="checkbox"/> Aetna Medicare |
| <input type="checkbox"/> Meritain Health (No Advent-Health) | <input type="checkbox"/> Blue Medicare Advantage |
| <input type="checkbox"/> All Savers | <input type="checkbox"/> Humana Medicare Health Plan |
| <input type="checkbox"/> Blue Cross (NO NKC Hospital / NO OEG, KWF) | <input type="checkbox"/> United Healthcare Medicare Solutions |
| <input type="checkbox"/> Cigna (No EPO Connect / SureFIT) | <input type="checkbox"/> Medicare Part B MUST BE PRIMARY |
| <input type="checkbox"/> Humana (No Humana One, PPOX) | <input type="checkbox"/> Railroad Medicare Part B MUST BE PRIMARY |
| <input type="checkbox"/> United Healthcare (No Core Plans) | |
| <input type="checkbox"/> UMR <input type="checkbox"/> GEHA <input type="checkbox"/> UnitedHealth Shared Services | |

**We do NOT accept
 Tricare, Medicaid or
 ACA Marketplace
 Plans
 (Blue Cross ACA
 Marketplace is
 accepted)**

- For Healthy Solutions Staff ONLY
- Cash
- Check # _____
- Amount Paid \$ _____
- Employer Paid
- Healthy Solutions Coupon

Print Name _____
(NAME OF PERSON RECEIVING VACCINE - EXACTLY AS LISTED WITH INSURANCE COMPANY)

Member ID # _____
(REQUIRED FOR ALL INSURANCES LISTED ABOVE) (SUFFIX)

I have been offered a copy of the "Vaccine Information Statement" for the vaccine(s) I receive today. I have read the information about the influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of the influenza vaccination and request that the vaccine be given to me or the person named above for whom I am authorized to sign. I agree that Healthy Solutions, Inc. is not responsible or liable if I contract influenza, other respiratory diseases, or suffer any other adverse reaction or event following administration of the influenza vaccine. This vaccination is being given to me at my request. As a condition of receiving the vaccine, I, myself, my heirs and executors hereby waive any right I may have to make a claim against Healthy Solutions, Inc. and the sponsoring organization, their affiliates, divisions, subsidiaries, officers, directors, advisory boards, employees, and contractors from any and all claims arising out of, in connection with, or in any way related to my receiving the influenza vaccine. I authorize Healthy Solutions, Inc. to furnish information to and receive payment from insurance companies for services provided me. I understand that these records may be protected by Federal Regulations and have been offered Healthy Solutions, Inc.'s Notice of Privacy Practices. In order to provide program participation Healthy Solutions, Inc. may provide my name to the sponsoring organization or its designated representative. I agree that Healthy Solutions, Inc., its agents and employees, are not liable if individuals or companies to whom they release information disclose the information without my consent. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccination.

I AGREE TO WAIT IN THE AREA FOR 15 MINUTES AFTER RECEIVING THE VACCINATION(S).

The acceptance of your health insurance information does not guarantee coverage or payment by your insurance company.
I fully understand that I will be responsible for charges if insurance or Medicare does not pay.

Participant Signature _____ Date: _____
(65 years of age and older)

Manufacturer	Lot	Exp. Date	Injection Site	Vaccine	Nurse Signature
<input type="checkbox"/> Seqirus .5ml			<input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid	<input checked="" type="checkbox"/> Prefilled Syringe	
<input type="checkbox"/> Sanofi .7ml					